Understanding the Essentials of Critical Care Nursing 3rd edition Perrin Test Bank

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MULTIPLE CHOICE. Choose the one alternative that best completes the statement or answers the question.

1) The nurse identifies a patient in the critical care unit as having "resiliency." What characteristic has the nurse identified in the patient?
   A) Motivation to reduce anxiety through positive self–talk
   B) Ability to return to a state of equilibrium
   C) Physical strength to endure extreme physical stressors
   D) Ability to bounce back quickly after an insult

   Answer: D

2) While caring for a patient in the critical care unit, the nurse realizes that the patient's care needs must be a balance between the patient's long–term prognosis and the family's expectations of recovery. Which AACN Synergy Model characteristic does this situation describe?
   A) Resource availability
   B) Predictability
   C) Complexity
   D) Participation in care

   Answer: C

3) The nurse realizes that which stressor is one of the primary concerns of critically ill patients and should be routinely included during assessments?
   A) Lack of family support
   B) Inability to control elimination
   C) Altered ability to communicate
   D) Hunger

   Answer: C

4) A patient has just completed a preoperative education session prior to undergoing coronary artery bypass surgery. Which patient statements indicate that teaching has been effective? Select all that apply.
   Note: Credit will be given only if all correct choices and no incorrect choices are selected.
   A) "I understand that I will have to blink my eyes to respond after the breathing tube is in my throat."
   B) "I will be given frequent mouth care to help me when I am thirsty."
   C) "I may need something to help me rest due to the unfamiliar lights and sounds of the ICU unit."
   D) "I might not behave like my usual self after the surgery, but it will be because of the medications and my illness."
   E) "I will be able to move about freely in bed and into the chair without help while connected to the electronic equipment for monitoring."

   Answer: A, B, C, D

5) When providing care to critically ill patients, whether they are responsive or unresponsive, what should the nurse do?
   A) Clearly explain what care is to be done before starting the activity.
   B) Explain to the family that the patient will not understand or remember any of the discomfort associated with care.
   C) Make sure the patient always responds and is cooperative before giving care.
   D) Perform the activity and then let the patient rest without explaining the care.

   Answer: A

6) Which communication strategy should the critical care nurse use when communicating with a ventilated patient?
   A) Use simple language and explain in other terms if the patient does not seem to understand.
   B) Provide minimal information so the patient is not overwhelmed.
   C) Use professional terminology and provide the patient with detailed information.
   D) Discuss issues primarily with the family because the patient is unlikely to understand the information.

   Answer: A

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7) During an assessment, a ventilated patient begins to frown and wiggle about in bed. Which assessment strategy would be most helpful for the nurse to validate these observations?
A) Maslow's hierarchy levels
B) Vital signs trends
C) Critical–Care Pain Observation Tool (CPOT)
D) Glasgow Scale

Answer: C

8) Which parameter indicates that a patient in the intensive care unit being mechanically ventilated is ready for an interruption in sedation? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
A) Frowns when turned but otherwise shows no muscular tension
B) Awakens with verbal stimuli
C) Activates the ventilator alarms, but the alarms stopped spontaneously
D) MAP of 75 and heart rate of 76
E) Receives neuromuscular blocking agents to ensure adequate ventilation

Answer: A, B, C, D

9) A patient scores positive on the Confusion Assessment Method of the Intensive Care Unit (CAM–ICU). Which nursing diagnosis would have the highest priority based on this positive score?
A) Social Interaction, Impaired
B) Family Processes, Altered
C) Memory Impaired
D) Injury, Risk for

Answer: D

10) Which nursing action would be appropriate when the nurse initiates an infusion of morphine sulfate for a post–operative patient who is experiencing pain?
A) Anticipate that the patient will begin to experience the effect of the morphine 15 minutes after the start of the infusion.
B) Provide additional intermittent boluses of morphine sulfate if the patient experiences breakthrough pain.
C) Begin the infusion at the lowest ordered dose, and increase the rate every 30 minutes if the patient continues to have pain.
D) Complete the Critical–Care Pain Observation Tool scale 5 minutes after increasing the infusion rate each time.

Answer: B

11) Which strategies should the nurse include in the plan of care when trying to minimize sleep disruptions for a patient in an ICU?
Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
A) Scheduling treatments only during the day or at least 4 hours apart at night
B) Instituting a short course of therapy for sleeping agents
C) Managing the environment to reduce lighting and sound
D) Accurate scoring and vigilance in sedation and sedation scoring
E) Minimizing staff interruptions during sleep periods

Answer: B, C, D, E

12) The nurse confirms medication orders and the schedule to administer a sedative to a patient with delirium. Which dosing schedule maximizes the effectiveness of the drugs?
A) Only at bedtime (HS)
B) Only in the early morning
C) Around the clock with higher dosages in the evening
D) Only on an as–needed (PRN) basis

Answer: C

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13) The charge nurse reviews information about patients received during morning report. Which patient is at risk for nutritional imbalances? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
A) Client recovering from a myocardial infarction
B) Client recovering from extensive burns
C) Client receiving hemodialysis treatments 3 times a week
D) Client with slightly elevated liver enzymes
E) Client who is intubated for respiratory failure

Answer: A, B, C, E

14) Members of the multidisciplinary care team review a patient's nutritional status and analyze assessment values. Which value would need additional investigation?
A) A serum albumin of more than 3.5 g/dL or 35 g/L
B) A prealbumin level of 35 mg/dL
C) A serum hemoglobin of 11.7 g/dL or 117 mmol/L
D) A weight increase of 1.5 kg in a day

Answer: D

15) The nurse inserts a nasogastric tube and plans to confirm placement of the tube prior to starting enteral feedings. Which is the most accurate method for confirming tube placement?
A) Instilling 30 mL of air while listening with a stethoscope when placed over the fundus of the stomach
B) Obtaining a radiological x–ray of the abdomen
C) Determining the presence of carbon dioxide
D) Checking gastric aspirate for a pH of less than 7

Answer: B

16) Which nursing diagnosis should receive the highest priority when caring for a patient who is receiving total parenteral nutrition?
A) Infection, Risk for
B) Skin Integrity, Impaired
C) Trauma, Risk for
D) Fluid Volume, Risk for Imbalance

Answer: A

17) What should the nurse do to meet the needs of the critically ill patient's family members? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
A) State specific facts about the patient's condition in a timely manner
B) Communicate to a single family member to cut down time wasted repeating information to all visitors
C) Express an attitude of hope, honesty, open communication, and caring
D) Plan regular times for family visits throughout the day
E) Limit the number of visitors to significant others

Answer: A, C, D

18) Which statement describing the needs of family members of critically ill patients has yet to be validated by research?
A) "Hovering" in the proximity phase is characterized by confusion and tension.
B) "Not knowing is the worst part" of waiting.
C) Families in the waiting room have no effect on patient outcomes.
D) A unified message from staff minimizes family stressors.

Answer: C

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19) The nurse addresses the family needs of a critically ill patient. Which family need was not identified?
A) Information B) Assurance C) Proximity D) Timeliness

Answer: D

20) When planning care to meet the needs of families of critically ill patients, the nurse should include which strategies by Miracle (2006)? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
A) Frequent verbal communication to clarify the purpose of unit, equipment, procedures, waiting areas, phones, and so on
B) Regular family conferences to meet patient goals and progress
C) A way to contact family through a specific family member by phone if needed
D) A consistent nurse, and unified staff responses if that nurse is not available
E) Information about how to contact the primary doctor if needed

Answer: B, D, E

21) A physician suggests that a patient being mechanically ventilated, needing immediate transport to CT scan, and having severe pain be given IV fentanyl (Sublimaze) rather than morphine sulfate for pain management. Why is fentanyl (Sublimaze) preferred?
A) Weaning of a continuous infusion is never needed due to its short half–life.
B) It has a more rapid onset and a shorter duration of action.
C) Rapid administration does not have any hemodynamic consequences.
D) It is not likely to cause respiratory depression.

Answer: B

22) A patient being mechanically ventilated receives midazolam (Versed) for sedation. What findings indicate to the nurse that the patient is receiving an appropriate dose of this medication?
A) Asleep but withdrawing from noxious stimuli with a heart rate of 80
B) Awake with a respiratory rate of 38 and a heart rate of 132
C) Asleep but awakening to light touch with a heart rate of 72
D) Awake with a heart rate of 124 and attempting to pull out the IV

Answer: C

23) The nurse cares for a patient recovering from surgery who is being mechanically ventilated and experiencing pain. Which approach should the nurse use first to assess this patient's pain?
A) Ask the patient if he or she is in pain B) Observe the patient's face for grimacing
C) Attempt an analgesic trial D) Ask a family member if the patient is in pain

Answer: A

24) The nurse administers haloperidol (Haldol) via IV push to a patient experiencing delirium. What is most important for the nurse to monitor in this patient?
A) PR interval B) Heart rate C) QT interval D) Respiratory rate

Answer: C

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25) The nurse assesses a critically ill patient utilizing the AACN Synergy Model's characteristics. Which characteristics are identified as impacting the outcome of a critically ill patient? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
A) Resource availability
B) Level of consciousness
C) Stability
D) Participation in care
E) Complexity

Answer: A, C, D, E

26) The nurse plans care for a critically ill patient. What should the nurse include to address the patient's major areas of concern? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
A) Determine a method of communication.
B) Explain the purpose of the intravenous tubes.
C) Explain the purpose of the tube in the nose.
D) Explain the purpose of the tube in the mouth.
E) Ensure that the room lights will be turned off and alarms set to low volume.

Answer: A, B, C, D

27) The nurse providing care to a patient who is unresponsive and being mechanically ventilated uses unintentional distractions. What is the nurse doing when providing care? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
A) Talking to a colleague
B) Joking
C) Singing
D) Apologizing for causing pain
E) Humming

Answer: B, C, E

28) What strategies should the nurse use to communicate with an older adult patient who is intubated and being mechanically ventilated? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
A) Have questions and possible answers ready so the patient can point to the response.
B) Ask several questions at a time to limit interruptions in rest periods.
C) Make sure the patient is wearing eyeglasses.
D) Speak slowly.
E) Decide on which gestures mean "yes" and "no."

Answer: A, C, D, E

29) A patient in the critical care unit demonstrates increasing agitation. What should the nurse use to assess this patient's agitation level? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
A) Glasgow Scale
B) Ventilator Adjusted Motor Assessment Scoring Scale
C) Richmond Agitation–Sedation Scale (RASS)
D) Sedation Assessment Scale (SAS)
E) Reaction Level Scale

Answer: C, D

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30) The nurse plans to use music therapy to help reduce a critically ill patient's level of anxiety. What should the nurse do when using this complementary and alternative therapy? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
A) Listen to the music in advance to make sure it does not have lyrics.
B) Ask family members to identify the patient's preferred music.
C) Play the music from a CD player on the bedside table.
D) Plan for the music to be played for 30 uninterrupted minutes.
E) Ensure that the music beats are between 60 to 80 per minute.

Answer: A, B, D, E

31) The nurse assesses the nutritional needs of a patient in the intensive care unit. What information is essential for the nurse to obtain during this assessment? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
A) Patient's current height and weight
B) Amount of water consumed each day
C) Food allergies
D) Use of nutritional supplements
E) If the patient can swallow

Answer: A, C, D, E

32) The nurse is a member of a committee that is designing improvements to the critical care waiting areas. What improvements should the nurse suggest to enhance the comfort of family members of critical care patients? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
A) Use dark paint and minimal lighting in the waiting areas.
B) Provide coffee and soft drinks in the waiting area.
C) Plan for a large space to be used for the waiting areas.
D) Place televisions and DVD players in the waiting area.
E) Find space for sleeping rooms.

Answer: B, C, D, E

33) The nurse uses the Synergy Model patient characteristics to plan care for a patient in the intensive care area. Which observations indicate that these actions were effective? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
A) Patient thanks the nursing staff for help with basic care needs
B) Patient expresses dissatisfaction with morning care
C) Patient rests between procedures and medication administration
D) Patient states that he or she is feeling better and is eager to return home
E) Patient extubated two days earlier than expected

Answer: A, C, D, E

34) A critically ill patient is prescribed enteral feedings to begin after placement of the nasogastric tube is verified. What should the nurse identify as the goal for this method of nutrition?
A) Avoid aspiration pneumonia
B) Reduce the need for pain medication
C) Enhance respiratory excursion
D) Prevent infection

Answer: D

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35) A newly admitted patient receiving sedation is prescribed parenteral nutrition via a central line. Which action should the nurse take to prevent overfeeding of this patient?

A) Evaluate albumin levels
B) Monitor daily weights
C) Question the order to infuse lipids
D) Use an infusion pump

Answer: C

36) Weekly group meetings are scheduled every Wednesday afternoon for the families of current intensive care patients. What should the nurse prepare in anticipation of the next meeting?

A) Location of the waiting area
B) Equipment and treatments the patients receive
C) The schedule of when to telephone for patient status updates
D) Visiting hours for the unit

Answer: B

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